FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030551

Facility Name: BRIGHTVIEW CARE CENTER

Address: 4538 N. BEACON (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 275-7200 **Fax #** (773) 275-7543

IDPA ID Number: 363408520001

Date of Initial License for Current Owners: 02/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY N. DRAZNER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	34,507	886	1,984	37,377	8
9	SNF/PED					9
10	ICF	10,227	263	13	10,503	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,734	1,149	1,997	47,880	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.73%

D. How many bed-hold days during this year were paid by Public Aid?
789 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,938

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	189,854	32,117	10,500	232,471		232,471		232,471			1
2	Food Purchase		235,792		235,792	(19,290)	216,502	(56)	216,445			2
3	Housekeeping	207,519	56,964		264,483		264,483	739	265,222			3
4	Laundry	78,844	13,730		92,574		92,574		92,574			4
5	Heat and Other Utilities			112,125	112,125		112,125	2,225	114,350			5
6	Maintenance	55,375	23,963	37,996	117,334		117,334	(12,318)	105,016			6
7	Other (specify):*							28	28			7
8	**TOTAL General Services**	531,592	362,566	160,621	1,054,779	(19,290)	1,035,489	(9,383)	1,026,106			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,576,228	114,372	13,786	1,704,386		1,704,386	301	1,704,687			10
10a	Therapy	75,558	1,467	11,140	88,165		88,165		88,165			10a
11	Activities	80,306	4,763	2,623	87,692		87,692		87,692			11
12	Social Services	114,536		2,077	116,613		116,613		116,613			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,846,628	120,602	34,426	2,001,656		2,001,656	301	2,001,957			16
	C. General Administration											
17	Administrative	168,052		72,000	240,052		240,052	32,829	272,881			17
18	Directors Fees											18
19	Professional Services			264,455	264,455	(91)	264,364	(208,124)	56,240			19
20	Dues, Fees, Subscriptions & Promotions			32,293	32,293		32,293	(13,508)	18,785			20
21	Clerical & General Office Expenses	135,076	27,349	104,511	266,936		266,936	1,337	268,273			21
22	Employee Benefits & Payroll Taxes			361,224	361,224	19,290	380,514		380,514			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,770	1,770		1,770	699	2,469			24
25	Other Admin. Staff Transportation			630	630		630	88	718			25
26	Insurance-Prop.Liab.Malpractice			143,082	143,082		143,082	732	143,814			26
27	Other (specify):*							27,898	27,898			27
28	**TOTAL General Administration**	303,128	27,349	979,965	1,310,442	19,199	1,329,641	(158,049)	1,171,592			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,681,348	510,517	1,175,012	4,366,877	(91)	4,366,786	(167,131)	4,199,655			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRIGHTVIEW CARE CENTER #0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			74,838	74,838		74,838	48,776	123,614			30
31	Amortization of Pre-Op. & Org.							33,433	33,433			31
32	Interest			39,650	39,650		39,650	145,917	185,567			32
33	Real Estate Taxes					91	91	145,609	145,700			33
34	Rent-Facility & Grounds			416,016	416,016		416,016	(416,016)				34
35	Rent-Equipment & Vehicles			598	598		598	(108)	490			35
36	Other (specify):*											36
37	**TOTAL Ownership**			531,102	531,102	91	531,193	(42,389)	488,804			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,148	105,385	203,533		203,533		203,533			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*	63,578			63,578		63,578	(63,578)	0			43
44	**TOTAL Special Cost Centers**	63,578	98,148	183,678	345,404		345,404	(63,578)	281,826			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,744,926	608,665	1,889,792	5,243,383		5,243,383	(273,098)	4,970,285			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(68,465)	30		9
10	Interest and Other Investment Income	(9,424)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(270)	21		18
19	Entertainment				19
20	Contributions	(9,350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(71,617)	21		24
25	Fund Raising, Advertising and Promotional	(2,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,943)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(93,707)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (261,824)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,274)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (11,274)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (273,098)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

BRIGHTVIEW CARE CENTER

ID# 0030551

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing salaries	$ (63,578)	43	1
2	Capitalized R&M	(16,876)	06	2
3	Theft & Loss	(3,038)	21	3
4	Non allowable professional Fees	(5,000)	19	4
5	IL Council on LTC - COPE	(2,364)	20	5
6	Building Co Accounting Fees	(2,245)	19	6
7	Auto Lease	(598)	25	7
8	Bank Charges - Building Co	(8)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(93,707)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(56)											(56)	2
3	Housekeeping			739									739	3
4	Laundry													4
5	Heat and Other Utilities			1,052		1,173							2,225	5
6	Maintenance	(16,876)		3,585		973							(12,318)	6
7	Other (specify):*					28							28	7
8	**TOTAL General Services**	(16,933)		5,376		2,174							(9,383)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			301									301	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			301									301	16
	C. General Administration													
17	Administrative			54,819	(22,517)	527							32,829	17
18	Directors Fees													18
19	Professional Services	(7,245)		(201,356)	324	153							(208,124)	19
20	Fees, Subscriptions & Promotions	(14,705)	595	522	76	4							(13,508)	20
21	Clerical & General Office Expenses	(80,875)	2,473	79,599	34	106							1,337	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			699									699	24
25	Other Admin. Staff Transportation			88									88	25
26	Insurance-Prop.Liab.Malpractice			634		98							732	26
27	Other (specify):*			26,285	1,613								27,898	27
28	**TOTAL General Administration**	(102,826)	3,068	(38,710)	(20,470)	888							(158,049)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,759)	3,068	(33,033)	(20,470)	3,062							(167,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(68,465)	106,632	7,704	1,638	1,267							48,776	30
31	Amortization of Pre-Op. & Org.		33,433										33,433	31
32	Interest	(9,424)	153,005	289		2,048							145,917	32
33	Real Estate Taxes		143,755			1,854							145,609	33
34	Rent-Facility & Grounds		(416,016)	10,161		(10,161)							(416,016)	34
35	Rent-Equipment & Vehicles	(598)		490									(108)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(78,487)	20,809	18,644	1,638	(4,992)							(42,389)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(63,578)											(63,578)	43
44	**TOTAL Special Cost Centers**	(63,578)											(63,578)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(261,824)	23,877	(14,389)	(18,832)	(1,930)							(273,098)	45

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 555,771	BRIGHTVIEW BUILDING CO.	100.00%	$ 139,755	$ (416,016)	1
2	V	34	RENTAL INCOME - R/E TAX		BRIGHTVIEW BUILDING CO.	100.00%			2
3	V	32	INTEREST INCOME	81,173	BRIGHTVIEW BUILDING CO.	100.00%		(81,173)	3
4	V	32	MORTGAGE INTEREST EXP		BRIGHTVIEW BUILDING CO.	100.00%	6,531	6,531	4
5	V	30	DEPRECIATION		BRIGHTVIEW BUILDING CO.	100.00%	106,632	106,632	5
6	V	31	AMORTIZATION		BRIGHTVIEW BUILDING CO.	100.00%	33,433	33,433	6
7	V	33	R/E TAX		BRIGHTVIEW BUILDING CO.	100.00%	143,755	143,755	7
8	V	20	ANNUAL FEE		BRIGHTVIEW BUILDING CO.	100.00%	595	595	8
9	V	21	G&A EXPENSE		BRIGHTVIEW BUILDING CO.	100.00%	2,473	2,473	9
10	V	32	OTHER INTEREST EXPENSE		BRIGHTVIEW BUILDING CO.	100.00%	227,647	227,647	10
11	V								11
12	V								12
13	V								13
14	Total			$ 636,944			$ 660,821	$ * 23,877	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 739	$ 739	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,052	1,052	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,585	3,585	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	301	301	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	51,540	51,540	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,132	1,132	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	522	522	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	79,599	79,599	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	699	699	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	88	88	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	634	634	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	26,285	26,285	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	7,704	7,704	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	289	289	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	10,161	10,161	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	490	490	30
31	V	19	HOME OFFICE	202,488	MANAGCARE, INC.	100.00%		(202,488)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	755	755	32
33	V	17	ADMIN. SALARY - YEHOSHUA DAVIS		MANAGCARE, INC.	100.00%	2,524	2,524	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,488			$ 188,099	$ * (14,389)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 49,483	$ 49,483	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	324	324	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	76	76	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	34	34	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,613	1,613	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,638	1,638	20
21	V								21
22	V	17	MANAGEMENT FEES	72,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(72,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 53,168	$ * (18,832)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,173	$ 1,173	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		973	973	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		28	28	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		527	527	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		153	153	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		4	4	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		106	106	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		98	98	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		1,267	1,267	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,048	2,048	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		1,854	1,854	25
26	V	34	RENT	10,161	MAZEL MANAGEMENT			(10,161)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,161			$ 8,231	$ * (1,930)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Owner	Administrative	72.34%	See Attached	10	16.67%	Salary	$ 15,106	17-1	1
2	Yosef Davis				See Attached			Inter Care	49,483	17-7	2
3	Moshe Davis	Dir of Operations	Administrative		See Attached	2.8	7.00%	Salary	14,955	17-1	3
4	Moshe Davis				See Attached			Inter Care	755	17-7	4
5	Yehoshua Davis	Administrator	Administrative		See Attached	13.4	33.50%	Salary	57,106	17-1	5
6	Yehoshua Davis				See Attached			Inter Care	2,524	17-7	6
7	Shoshana Braun	Relative	Clerical		See Attached	15.6	39.00%	Salary	15,577	10-1	7
8	Moshe Wolf	Owner	Administrative	2.13%	See Attached	11	19.64%	ManagCare	13,688	17-7	8
9	Moshe Wolf				See Attached			Mazel	527	17-7	9
10	Stanley Klem	Owner	Administrative	2.13%	See Attached	8	20.00%	ManagCare	22,425	17-7	10
11	Chasida Davis	Relative	Clerical		See Attached	7.9	19.75%	ManagCare	7,343	17-7	11
12	Renee Wolf	Relative	Clerical		See Attached	7.9	19.75%	ManagCare	3,699	17-7	12
13								TOTAL	$ 203,188		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	1,022,352	4	$ 3,731	$	202,488	$ 739	1
2	5	UTILITIES	BOOKEEPING INC.	1,022,352	4	5,310		202,488	1,052	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,022,352	4	18,100		202,488	3,585	3
4	10	NURSING SALARIES	BOOKEEPING INC.	1,022,352	4	1,521	1,521	202,488	301	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,022,352	4	260,224	260,224	202,488	51,540	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,022,352	4	5,715		202,488	1,132	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,022,352	4	2,636		202,488	522	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	1,022,352	4	401,889	331,028	202,488	79,599	8
9	24	SEMINARS	BOOKEEPING INC.	1,022,352	4	3,530		202,488	699	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,022,352	4	446		202,488	88	10
11	26	INSURANCE	BOOKEEPING INC.	1,022,352	4	3,203		202,488	634	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	1,022,352	4	132,710		202,488	26,285	12
13	30	DEPRECIATION	BOOKEEPING INC.	1,022,352	4	38,898		202,488	7,704	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,022,352	4	1,461		202,488	289	14
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	1,022,352	4	51,300		202,488	10,161	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,022,352	4	2,474		202,488	490	16
17										17
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	7,405	7,405	4	755	18
19	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	7,547	7,547	13	2,524	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 948,100	$ 607,725		$ 188,099	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	$ 296,900	$ 296,900	10	$ 49,483	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	1,945		10	324	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	456		10	76	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	207		10	34	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	9,679		10	1,613	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	9,829		10	1,638	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 319,016	$ 296,900		$ 53,168	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC.	1,022,352	4	$ 5,921	$	202,488	$ 1,173	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC.	1,022,352	4	4,914	1,820	202,488	973	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC.	1,022,352	4	139		202,488	28	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC.	1,022,352	4	2,660		202,488	527	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC.	1,022,352	4	770		202,488	153	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC.	1,022,352	4	22		202,488	4	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC.	1,022,352	4	535		202,488	106	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC.	1,022,352	4	494		202,488	98	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC.	1,022,352	4	6,395		202,488	1,267	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC.	1,022,352	4	10,340		202,488	2,048	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC.	1,022,352	4	9,359		202,488	1,854	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 41,549	$ 1,820		$ 8,231	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Manufacturer's Bank		X	Line of Credit			$	$			$ 39,336	1
2	Manufacturer's Bank		X	Auto	$339	1/7/00				7.25%	314	2
3	Mid North Financial		X	Mortgage - Building Co.	$35,116					10.50%	55,888	3
4	Building Co	X										4
5	MB Financial		X	Mortgage			4,000,000	3,944,981	02/01/07	Prime	178,290	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,455.46		$ 4,000,000	$ 3,944,981			$ 273,828	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(88,261)	10
11	Mid America	X										11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (88,261)	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 3,944,981			$ 185,568	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (9,424)	1
2	Interest Income - Building Co.	X									(81,173)	2
3	Allocation - ManagCare	X									289	3
4	Allocation - Mazel Management	X									2,048	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (88,261)	21

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	140,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	141,609	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,609	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	144,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	91	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 272 For 1995 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	145,700	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	144,564	8
1998	147,131	9
1999	146,143	10
2000	136,212	11
2001	139,755	12

Accrual 136212 x 1.05 = rounded off to 144,000

Refund has not been offset since it relates to a tax year which was not used to calculate a rate.

Related Parrty expense allocated $1839.43

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIGHTVIEW CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Nursing Home Property	$ 55,664.16	$ 55,664.16
2.	14-17-115-018-0000	Nursing Home Property	$ 54,910.80	$ 54,910.80
3.	14-17-115-030-0000	Nursing Home Property	$ 29,179.60	$ 29,179.60
4.	See attached	Allocated - Managecare	$ 40,508.85	$ 1,839.43
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,263.41	$ 141,593.99

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIGHTVIEW CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 101,802
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 33,433
4. Dates Incurred: 1993, 1/27/2002

Nature of Costs: 72,202 old mortgage balance of costs (28,006) written off. 29,600 costs of refinance amortized over 5 years
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 73,992	1
2					2
3	TOTALS			$ 73,992	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306		20	543	543	9,024	9
10	Various			1987	4,719		20	236	236	3,660	10
11	Various			1988	2,895		20	145	145	2,150	11
12	Various			1989	67,265		20	3,272	3,272	46,321	12
13	Various			1991	22,384		20	1,120	1,120	10,882	13
14	Various			1992	17,019		20	143	143	14,038	14
15	Various			1993	44,200		20	2,211	2,211	20,868	15
16	Various			1994	63,594		20	3,181	3,181	27,117	16
17	Various			1995	7,105		20	356	356	2,698	17
18	Various			1996	37,640		20	1,882	1,882	12,803	18
19	Various			1997	17,411		20	871	871	4,428	19
20	Various			1998	49,850		20	2,497	2,497	10,866	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,951,797	109,423		56,539	(52,884)	1,629,469	68
69	Financial Statement Depreciation			74,838			(74,838)		69
70	TOTAL (lines 4 thru 69)		$ 2,296,185	$ 184,261		$ 72,996	$ (111,265)	$ 1,794,324	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,296,185	$ 184,261		$ 72,996	$ (111,265)	$ 1,794,324	1
2	BOILER REPAIR	1999	2,500		20	125	125	479	2
3	GENERATOR	1999	100,000		20	5,000	5,000	17,917	3
4	WINDOWS	1999	58,097		20	2,905	2,905	10,410	4
5	DAMPERS & GRILLS	1999	19,323		20	966	966	3,462	5
6	LIFE SAFETY CONSULT	1999	930		20	47	47	168	6
7	CONSTRUCTION CONSULT	1999	2,980		20	149	149	534	7
8	EMERGENCY SYSTEM	1999	4,000		20	200	200	700	8
9	FIRE EQUIPMENT	1999	2,162		20	108	108	432	9
10	ELEVATOR	1999	4,600		20	230	230	824	10
11	FIREDOOR MASONRY	1999	4,200		20	210	210	700	11
12	EXHAUST FANS	1999	3,230		20	162	162	500	12
13	CCTV SYSTEM	1999	4,391		20	220	220	678	13
14	TELEPHONE SYSTEM	1999	730		20	37	37	114	14
15	ELECTRIC DOOR	1999	836		20	42	42	140	15
16	INTERCOM	1999	557		20	28	28	93	16
17	ASPHALT REPAIRS	1999	4,015		20	201	201	687	17
18	TUCKPOINTING	1999	1,350		20	68	68	249	18
19	ALARM SYSTEM	1999	1,583		20	79	79	303	19
20	SHAFT BEARING	2000	4,307		20	215	215	484	20
21	BOILER	2000	1,650		20	83	83	201	21
22	SHAFT BEARING	2000	2,344		20	117	117	273	22
23	EMERGENCY GENERATOR	2000	18,892		20	945	945	2,441	23
24	BOILER	2000			20				24
25	ELECTRIC CONNECTIONS	2000	6,326		20	316	316	658	25
26	COMPUTER CABLE RUN	2000	4,903		20	245	245	592	26
27	TELEPHONE LINES	2000	2,892		20	145	145	375	27
28	VIDEO MONITORING SYS	2000	3,615		20	181	181	543	28
29	RAMP RAILING EXTNSN	2000	1,000		20	50	50	129	29
30	COMM/ACS PROCESSOR	2000	1,346		20	67	67	179	30
31	KICKPLATES FOR DOORS	2000	559		20	28	28	63	31
32	ALARMS	2001	10,314		20	516	516	817	32
33	ELECTRICAL WORK	2001	2,740		20	137	137	217	33
34	TOTAL (lines 1 thru 33)		$ 2,572,557	$ 184,261		$ 86,818	$ (97,443)	$ 1,839,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,572,557	$ 184,261		$ 86,818	$ (97,443)	$ 1,839,686	1
2	REWIRE PATIO	2001	2,575		20	129	129	204	2
3	DOOR DETECTORS	2001	3,600		20	360	360	720	3
4	ELEVATOR VALVE	2001	2,900		20	290	290	387	4
5	MOTOR PANEL	2001	1,800		20	180	180	210	5
6	CIRCUIT & OUTLET	2001	1,195		20	60	60	65	6
7	CCTV MONITOR	2001	1,206		20	60	60	70	7
8	CCTV BASEMT MONITOR	2001	1,037		20	52	52	56	8
9	DOOR EDGE PROTECTORS	2001	2,318		20	116	116	222	9
10	WALL HEATER	2001	696		20	35	35	38	10
11	A/C REPAIR	2001	1,185		20	59	59	98	11
12	MOTOR	2001	847		20	42	42	56	12
13	ELEVATOR PARTS	2001	1,721		20	86	86	143	13
14	ELEVATOR REPAIRS	2001	900		20	45	45	68	14
15	DUCT INSTALL,FIRE DAMPER	2002	1,975		20	115	115	115	15
16	BOILER IGNITOR SAFETY CONTROL	2002	1,125		20	103	103	103	16
17	INSTALL NEW DETECTOR EDGE IN ELEVATOR	2002	2,100		20	70	70	70	17
18	CONRTOL PANELS	2002	5,525		20	138	138	138	18
19	ELEVATOR DOOR DETECTOR SYSTEM	2002	2,679		20	33	33	33	19
20	HOT WATER HEATER COIL	2002	1,422		20	10	10	10	20
21	SECURITY CAMERA FOR PKG LOT	2002	1,087		20	13	13	13	21
22	SECURITY CAMERA FOR REAR DOOR	2002	744		20	9	9	9	22
23	CALL PAD	2002	1,099		20	55	55	55	23
24	CONCRETE STEPS	2002	2,620		20	131	131	131	24
25	EJECTOR PUMP	2002	1,078		20	54	54	54	25
26	HALLWAY P.A. SYSTEM	2002	3,774		20	189	189	189	26
27	ELEVATOR	2002	5,862		20	293	293	293	27
28	SMOKE DETECTOR/CEILING	2002	1,409		20	70	70	70	28
29	TILES	2002	1,035		20	52	52	52	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,070	$ 184,261		$ 89,667	$ (94,594)	$ 1,843,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		1986	1968	$ 1,899,326	$ 106,632	35	$ 54,266	$ (52,366)	$ 1,594,393	4
5			1985		20,434	1,063	20	681	(382)	11,749	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - ManageCare			1997	2,382	213	20	238	25	1,290	9
10	Allocation - ManageCare			1993	187		20	9	9	89	10
11	Allocation - ManageCare			1988	292	9	20	14	5	208	11
12	Allocation - ManageCare			1986	22,098	1,129	20	1,012	117	18,391	12
13	Allocation - Mazel Management			2001	429	11	20	21	10	32	13
14	Allocation - Mazel Management			2000	217	6	20	11	5	25	14
15	Allocation - Mazel Management			1998	764	26	20	38	12	180	15
16	Allocation - Mazel Management			1997	713	18	20	36	18	190	16
17	Allocation - Mazel Management			1996	486	5	20	24	19	160	17
18	Allocation - Mazel Management			1995	110	3	20	5	2	42	18
19	Allocation - Mazel Management			1994	434	8	20	22	14	162	19
20	Allocation - Mazel Management			1993	256	7	20	13	6	121	20
21	Allocation - Mazel Management			1991	192	6	20	9	3	103	21
22	Allocation - Mazel Management			1990	298	6	20	15	9	184	22
23	Allocation - Mazel Management			1989	187	4	20	8	4	106	23
24	Allocation - Mazel Management			1987	424	8	20	7	(1)	424	24
25	Allocation - Mazel Management			1986	1,713	89	20	73	(16)	1,452	25
26	Allocation - Mazel Management			1985	119					119	26
27	Allocation - Intercare Ltd			2001	736	180	20	37	(143)	49	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,951,797	$ 109,423		$ 56,539	$ (52,650)	$ 1,629,469	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 245,021	$ 1,715	$ 23,464	$ 21,749	10	$ 122,880	71
72	Current Year Purchases	60,065	856	5,437	4,581	10	5,437	72
73	Fully Depreciated Assets	114,922				10	114,880	73
74								74
75	TOTALS	$ 420,008	$ 2,571	$ 28,901	$ 26,330		$ 243,197	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		TOYOTA CAMRY	1999	$ 20,600	$	$ 2,060	$ 2,060	5	$ 6,523	76
77		Alloc - Managecare	2001	33,519	3,969	1,647	(2,322)	5	8,094	77
78		Alloc - Intercare	2002	8,920	1,277	1,338	61	5	1,338	78
79										79
80	TOTALS			$ 63,039	$ 5,246	$ 5,045	$ (201)		$ 15,955	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,185,109	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	192,078	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	123,613	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(68,465)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,102,510	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 490 Description: Allocation From ManagCare $490
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 39,830	$		$ 39,830	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,037			5,037	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			60,518			60,518	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				63,122		63,122	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					13,726		13,726	12
13	Other (specify): See Supplemental						21,300		21,300	13
14	TOTAL			$		$ 105,385	$ 98,148		$ 203,533	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 178,110	$ 354,237	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	925,721	937,151	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	186,836	186,836	6
7	Other Prepaid Expenses	2,684	2,684	7
8	Accounts Receivable (owners or related parties)	9,955	931,667	8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,306,306	$ 2,415,575	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,026,000	14
15	Leasehold Improvements, at Historical Cost	525,494	525,494	15
16	Equipment, at Historical Cost	435,765	515,765	16
17	Accumulated Depreciation (book methods)	(477,123)	(2,360,980)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		24,173	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 484,136	$ 880,452	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,790,442	$ 3,296,027	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 496,890	$ 496,891	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,342	51,342	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,698	108,698	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,561	10,561	31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,000	32
33	Accrued Interest Payable	5,498	5,498	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,276	1,276	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	687,177	6,562	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,361,442	$ 824,828	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,944,981	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,944,981	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,361,442	$ 4,769,809	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 429,000	$ (1,473,782)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,790,442	$ 3,296,027	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 156,959	1
2	Restatements (describe):		2
3	Replacement Tax	(1,606)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 155,353	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	273,647	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 273,647	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 429,000	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,405,550	1
2	Discounts and Allowances for all Levels	(385,887)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,019,663	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	308,990	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 308,990	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,420	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,643	19
20	Radiology and X-Ray	1,293	20
21	Other Medical Services	33,307	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 170,663	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,425	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,425	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,289	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,289	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,517,030	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,054,779	31
32	Health Care	2,001,656	32
33	General Administration	1,310,442	33
	B. Capital Expense		
34	Ownership	531,102	34
	C. Ancillary Expense		
35	Special Cost Centers	267,111	35
36	Provider Participation Fee	78,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,243,383	40
41	**Income before Income Taxes (line 30 minus line 40)****	273,647	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 273,647	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,104	$ 61,321	$ 29.14	1
2	Assistant Director of Nursing	1,936	2,136	59,680	27.94	2
3	Registered Nurses	14,685	16,705	465,566	27.87	3
4	Licensed Practical Nurses	18,867	22,346	410,208	18.36	4
5	Nurse Aides & Orderlies	55,427	62,166	540,708	8.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,988	8,782	75,558	8.60	8
9	Activity Director	1,989	2,211	20,063	9.08	9
10	Activity Assistants	8,078	8,653	60,243	6.96	10
11	Social Service Workers	7,997	8,760	114,536	13.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,961	22,919	189,854	8.28	15
16	Dishwashers					16
17	Maintenance Workers	3,962	4,444	55,375	12.46	17
18	Housekeepers	25,545	28,250	207,519	7.35	18
19	Laundry	9,970	10,676	78,844	7.39	19
20	Administrator	1,880	2,072	80,390	38.80	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	87,662	42.15	22
23	Office Manager					23
24	Clerical	11,462	12,642	135,076	10.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,626	2,958	38,745	13.10	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,699	1,899	63,578	33.48	33
34	TOTAL (lines 1 - 33)	199,103	221,800	$ 2,744,926 *	$ 12.38	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	260	$ 10,500	01-03	35
36	Medical Director	Monthly	4,800	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,373	10-03	39
40	Physical Therapy Consultant	108	5,790	10a-03	40
41	Occupational Therapy Consultant	79	4,378	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	18	972	10a-03	43
44	Activity Consultant	47	2,623	11-03	44
45	Social Service Consultant	41	2,077	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	552	$ 36,641		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 2,002	10-03	50
51	Licensed Practical Nurses		6,003	10-03	51
52	Nurse Aides		280	10-03	52
53	TOTAL (lines 50 - 52)		$ 8,285		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Miron Tabic	Administrator	0	$ 80,390
Yosef Davis	Administrative	72.34	15,106
Moshe Davis	Operations	0	14,955
Yehoshua Davis	Operations	0	57,601
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 168,052

B. Administrative - Other

Description	Amount
Management Fees - Intercare Ltd	$ 72,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 72,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Econocare	Purchasing service	$ 2,538
Personnel Planners	Unemployment Consultant	2,216
Winston & Strawn	Legal	350
Schmidt, Satzman & Moran	Legal	91
ManagCare	Bookkeeping	204,051
Frost Ruttenberg & Rothblatt	Accounting	47,898
JCAHO	Joint Commission	150
S&S Associates	Employment Consultant	2,000
Global Human Resource	IOC Consultant	5,160
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 264,454

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,145
Unemployment Compensation Insurance	20,836
FICA Taxes	206,076
Employee Health Insurance	66,312
Employee Meals	19,290
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	4,928
Holiday Expense	2,154
Chicago Head Tax	5,176
Employee Pension	6,842
Disability Insurance	3,756
TOTAL (agree to Schedule V, line 22, col.8)	$ 380,514

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	8,987
Health Care Worker Background Check	721
(Indicate # of checks performed 52)	
Licenses & Permits	1,968
Advertising & Promotion	2,991
Dues & Fees	7,876
IL Council on LTC - COPE	(2,364)
Related party allocation	1,197
Less: Public Relations Expense	( )
Non-allowable advertising	(2,991)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,785

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,770
Allocated from ManageCare	699
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,469

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $5379**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,619** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **78,293**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,290** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees